

determine how to “best fit” trauma care in Ireland to international models.

Methods: An estimate of Irish trauma burden and distribution was made using data from the Road Safety Authority (RSA) on serious or fatal RTAs. Models of a restructured trauma service were constructed and compared with international best practice.

Results: Trauma care is currently provided by 26 acute hospitals, with no Level I trauma center. (mean distance to hospital 20.6Km from site of RTAs). Based on our population, Ireland needs two Level 1 MTCs (in the two areas of major population density in the East and South), with robust surrounding trauma networks including level 2 or 3 trauma centers. With this model, the estimated mean number of cases per Level 1 MTC per year would be 628, with a mean distance to MTC of 80.5Km +/-59.2Km, (maximum distance 263.5Km).

Conclusions: Trauma care in Ireland is not in keeping with international models. To reform trauma services Ireland needs major trauma centers with surrounding comprehensive trauma networks and prehospital infrastructure.

1146: DOES THE INTRODUCTION OF AN EMERGENCY SURGICAL UNIT IMPROVE PATIENT WAITING TIMES?

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Introduction: In June 2013 a new Emergency Surgical Unit (ESU) with a dedicated emergency surgical team was introduced to the Royal Victoria Hospital, Belfast. Our aim was to determine if the introduction of the ESU improved time from A&E to senior surgical review. Time from decision to operate to surgery was also audited against current standards set out by the Royal College of Surgeons of England (RCS).

Methods: A retrospective review was carried out of patients admitted via A&E who had either an emergency laparotomy or appendicectomy during July and August 2012 (Group 1; n=22). This group was compared to patients who had an emergency laparotomy during June and July 2013 after the introduction of the ESU (Group 2; n= 24).

Results: The mean time from A&E consult to senior surgical review improved by approximately 30mins after the introduction of the ESU (194mins vs 166mins). The percentage of patients meeting the RCS target times was 81% in group 1 and 75% in group 2.

Conclusions: The introduction of an ESU has had a positive impact on patient waiting times to senior surgical review. This audit also identified time delays to theatre as an area that could still be improved upon.

1166: ADULT UPPER LIMB REPLANTATIONS AND REVASCULARISATION OUTCOMES: A 7-YEAR BIRMINGHAM AUDIT

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Introduction: There is limited literature on digital replantation, particularly from UK based centres. We report our experience of hand and digital replant and revascularisation procedures at a Trauma Centre in The West Midlands.

Methods: A retrospective analysis identified digit/hand replantations and revascularisations between October 2004 and September 2011. Mechanism of injury (MOI), operative details and outcomes were recorded from electronic patient records.

Results: 28 patients with mean age 39.4 years had 41 digit and 3 hand replants/revascularisations. Power-saw was the leading MOI (15/28). 9/33 replant and 9/11 revascularisation procedures were successful. All hand replant/revascularisations survived. Of single digit procedures, 8/13 replantations and 3/3 revascularisations survived. Multiple digit procedures had a worse outcome; 3/18 replantations and 2/7 revascularisations survived. No replantation/revascularisation survived if attempted beyond 12 hours ischaemia time and 27 digits ultimately required terminalisation. Complications occurred in 25 digits; 19 of these occurred within 24 hours of surgery. Of the 7 congested digits, all received leeches but only the 3 that commenced this within 24 hours survived.

Conclusions: Power-saw, multiple replanted digits and longer ischaemia time were predictors of poor outcome. Early leech therapy improved survival. Our results may reflect differences in MOI and a lower threshold for attempted replantation.

1190: 30-DAY MORTALITY OF EMERGENCY LAPAROTOMY IN A DISTRICT GENERAL HOSPITAL: A RETROSPECTIVE AUDIT

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Introduction: To compare the 30-day mortality rate (MR) following emergency laparotomy (EL) performed at our institution with the National Emergency Laparotomy Audit (NELA) results published in 2012.

Methods: List of EL performed from November, 2012 to October, 2013 retrieved. Electronic patient records and notes reviewed and demographics, intra-operative (Consultant presence, immediate complications) and post-operative data (Destination, 30-day MR, complications) were noted. Data was analysed using Microsoft Excel 2010 software.

Results: (n=90) patients, age 70 years, 24-90years (Median + IQ). Male to female ratio of 1.25:1. Non risk adjusted 30-day MR was 12% as compared to 14.2% national average. 30-day MR was 12.5% in cases performed during day time, 10.8% in evenings and 20% during night time. 30-day MR was 30.7% among those who required ITU care post-operatively. Median days of hospital stay were 19. Overall mortality was 38.4% in ASA 4 group. Consultant surgeon was present in 98.8% cases while anaesthetic consultant was available in theatre in 75% cases. Overall morbidity was 49%.

Conclusions: EL carries significant risk of morbidity and mortality. Procedures performed with consultant surgeon and anaesthetist's presence carry a favourable outcome. There is growing need of developing a national strategy to improve outcomes of EL in UK.

1206: COMPLIANCE WITH COLLEGE GUIDANCE ON OPERATIVE DOCUMENTATION IN LAPAROSCOPIC APPENDICECTOMY

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Introduction: Appendicitis represents the most common surgical abdominal emergency, affecting 7% of the population during their lifetime and laparoscopic appendicectomy is safe and effective for the treatment of uncomplicated appendicitis. With reducing thresholds for litigation, accurate and appropriate documentation of operative procedures and findings is crucial to minimise the burden to the NHS of legal action. This audit aimed to quantify compliance with i. RCSEng guidance; ii. local consensus on documentation from a medico legal perspective.

Methods: Operative records were assessed from 100 consecutive laparoscopic appendicectomies at a large DGH in 2013. Standards used were RCSEng published guidance and local consensus on important documentation items used in legal challenges.

Results: Seventy-eight records were fully compliant with RCS guidance, but none was fully compliant with medico legal documentation consensus. Documentation was particularly poor regarding perforation (16%), direct vision port insertion (34%), thromboprophylaxis instructions (34%) and comments on other organs (48%). The grade of trainee did not affect the standard of documentation ('SHO' vs 'SpR', p=0.466), but trainees outperformed Consultants (81% vs 33% RCSEng compliance, p=0.02).

Conclusions: Compliance with RCSEng guidance was good, but medico legally pertinent documentation was lacking. Training on medico legal aspects of documentation may be useful for trainees and Consultants alike.

1213: WHAT IS THE DIAGNOSTIC VALUE OF WHITE CELL COUNT, NEUTROPHIL COUNT, C-REACTIVE PROTEIN IN ACUTE AND PERFORATED APPENDICITIS?

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Introduction: White cell count (WCC), neutrophil count (NC) and C-reactive protein (CRP) are used as adjuncts in the diagnosis of appendicitis. The aim of this study was to determine the diagnostic accuracy of the above blood tests in acute and perforated appendicitis.

Methods: We retrospectively reviewed appendicectomies at a district general hospital in 2013. Operative and histology findings were correlated with admission blood tests.